

REPORT OF THE ILLINOIS ASSEMBLY

October, 2001

I. Introduction

In September 2000, the State of Illinois received a \$1.2 million State Planning Grant from the Health Research and Services Administration of the U.S. Department of Health & Human Services. The purpose of the grant is to develop a plan to assure access to health insurance for all Illinoisans. The grant funded two components of this planning: research on the characteristics of the uninsured in Illinois and a participatory process among diverse stakeholders to move toward consensus strategies to reduce the number of uninsureds in Illinois.

The grant gave Illinois the opportunity to gather state specific data which had not been available before. Several types of research were conducted, including a random digit dial survey, focus groups and key informant interviews, and an expansion of the Behavioral Risk Factor Surveillance System (BRFSS). Also, a website was created, information was gathered on a variety of potential strategies which have been used in other states, a literature review was undertaken, and a large bibliography was developed. The new data, as well as existing national data, served as a bridge between researchers and stakeholders during the participatory process of developing strategies to provide coverage to all uninsured persons in the State. The research results, as well as the results of the Illinois Assembly process are to be included in the Report to the Secretary of the Department of Health & Human Services which is due October 29, 2001.

The Illinois Department of Insurance is the lead agency for the State Planning Grant. Assistant Director Madelynne L. Brown serves as Project Director. A steering committee composed of representatives of State agencies and universities¹ and the Office of the Governor has guided the direction of the project.

II. The Illinois Assembly on the Uninsured Process

The Illinois Assembly on the Uninsured (the Assembly) was developed as a modified version of the American Assembly Model. Dwight D. Eisenhower pioneered the American Assembly process while President of Columbia University. It was chosen for its characteristics of engaging stakeholders in dialogue and encouraging a consensus building process among the stakeholders who take part in the participatory process. It has since been used successfully at the local, national, and international levels to develop policy on a variety of issues.

¹ Departments of Public Health, Public Aid, Commerce and Community Affairs, Human Services, Illinois Comprehensive Health Insurance Plan, Southern Illinois University at Carbondale and the University of Illinois at Chicago.

The Assembly was designed to allow stakeholders to move toward consensus on ways to initiate the process of reducing the number of uninsured to zero. Employers, labor unions, social service advocates, commercial insurers, insurance agents, medical practitioners and others share a fair amount of common ground on this issue, but rarely have had a chance to work cooperatively. The Assembly was an organized, interactive process where all of these entities could meet and work together to discuss ways to provide access to health insurance. The process has had covert and overt benefits beyond the specific work product that was created.

The Assembly convened in January 2001 to review the project and be introduced to the Assembly process. The major meeting of the Illinois Assembly on the Uninsured was convened for three days in Springfield, Illinois in July 2001. Former U.S. Senator Paul Simon, Director of the Public Policy Institute and Professor at Southern Illinois University Carbondale delivered remarks via videotape. Mike Lawrence, Public Policy Institute Associate Director helped guide the Assembly activity.

The July session consisted of three components:

1. Reports on research² results from the random digit dial survey of uninsured households; stakeholder focus groups and key informant interviews; the expanded Behavioral Risk Factor Surveillance System (BRFSS); and a review of programs currently in use in Illinois and highlights of strategies in use in other states were presented.
2. Participants were then divided into eight small heterogeneous groups to discuss strategies to provide coverage to the uninsured. The group make-up was designed to reflect balance between the organizations represented by the participants.
3. Guided by trained facilitators³ each group met for five sessions. Each session focused on separate target populations: small employers, children, young adults, working uninsured, and Hispanics and other minorities. Each group produced strategies for all target populations. These reports were compiled and distributed to caucus groups for review.

² Dr. Dianne Rucinski, University of Illinois Chicago, Mr. Bruce Steiner, Illinois Department of Public Health, Dr. Paul McNamara, Department of Agriculture and Consumer Economics, University of Illinois Urbana-Champaign, Dr. Paul Sarvela, Health Care Management, Southern Illinois University Carbondale, Dr. Peggy Stockdale, Southern Illinois University Carbondale, Dr. Caryl Cox, Program Evaluation for Education and Communities, Southern Illinois University Carbondale, Dr. Jane Swanson, Department of Psychology, Southern Illinois University Carbondale

³ Ms. Debbie Potts, *et al*, Illinois Office of Educational Services, Southern Illinois University Carbondale, Springfield, IL

Originally, the Assembly was to have prioritized the results of the small group deliberations during the July meeting. Due to the volume of strategies produced and a desire by members to consult with their constituencies, Assembly participants requested that the group be given time to digest the material prior to setting priorities. Subsequently a ballot was prepared and distributed to each participant. Participants selected their first, second and third choice of strategies for each target population and in an overall category. The ballot tabulation process is described in detail in the Appendix. The ballots were tabulated and the results distributed for comment to all those on the Illinois Assembly distribution list. The results for each ballot category are summarized in the Appendix.

Representatives of the insurance industry submitted a paper describing the industry's position on providing coverage to the uninsured that was distributed to all participants along with the ballot results. The insurance industry paper is in the Appendix to this report. Employers submitted a letter in October which is also in the Appendix.

A final plenary session of the Assembly was held September 10, 2001. During this one day session presentations were made by former Senator Paul Simon, Eric Brenner, Senior Policy Advisor to the Governor and Dr. John Lumpkin, Director of the Illinois Department of Public Health. The Assembly participants were given an opportunity to review and comment upon a draft of this report. In addition representatives of activists, employers, providers and insurers provided feedback on next steps.⁴ The September 10 discussion reinforced the general results of the balloting. A number of participants recommended that the Governor appoint a small group to determine which strategies should receive closer examination. It was also suggested that we establish pilots at the local level to test strategies. Strategies that are based on better consumer communication to increase uptake of available benefits, and incentives to attract employers to offer health benefits can be tested by coalitions and leading employers in Illinois.

III. Summary of Assembly Results

The balloting reflected three general, but important, areas of agreement. Review of the top four strategies by category and review of the Chart of Strategies shows the degree of consensus in each of these areas. It is important to note that specific methods of funding each strategy were not voted upon. Also it is recognized that in some cases the funding method selected could impact support for a strategy.

⁴ Pamela Mitroff, Pamela D. Mitroff, Consulting; Howard Peters, Illinois Hospital Association; Robyn Gabel, Illinois Maternal and Child Health Coalition; Jim Mortimer, Midwest Business Group on Health

The Illinois Assembly process resulted in three general areas being identified, out of the many areas proposed, for priority consideration in specific strategy development. To date we have neither selected, nor failed to select for implementation, any of the policy options developed through the consensus building process of the Assembly. Our next step is to develop specific models in the framework of these options. The following are the three options that received the greatest degree strong support from stakeholders during the participatory process and appear to be the most compelling for priority consideration:

1. There is strong support for provision of coverage to parents with children in KidCare (SCHIP), the proposed Family Care legislation. There was also support for expansion of both KidCare and Medicaid to undocumented immigrant children. There is substantial agreement on the need for additional options for covering entire families. Options for increasing family care range from increasing qualifying income percentages for eligibility for public programs to allowing opportunity to buy-in to existing public programs such as the state employee health insurance plan. These Assembly results mirror the shift in emphasis in the literature on providing health coverage for uninsured children, from children only to children as a part of the family group.
2. The Assembly reflected clear interest in providing support to the employer-based system. There was clear support for a strategy to implement incentives to employers that cut across all target populations. There was less consensus on exactly what techniques to use to do this. Specific strategies suggested include reinsurance schemes such as an expansion of ICHIP, the creation of purchasing pools, tax breaks, employer subsidies and the development of new insurance products. Such new products may require legislation to allow for flexibility and to reduce mandates. These strategies have had varying degrees of success when implemented in other states. Therefore as we continue the planning process we will have to look carefully at these ideas to assure long-term viability.
3. Considerable agreement exists in the Assembly that outreach, education and marketing activities need to be undertaken. Education strategies were proposed for several target populations. There is support for educating the uninsured population as well as small employers on the importance of health insurance coverage and how it works. Specifically there is consensus that these initiatives should concentrate on identifying and pursuing unique activities consistent with the socio-cultural or ethnic group(s) being targeted.

Cost is an issue in all the proposed strategies. During the July meeting of the Illinois Assembly each breakout group was charged with developing, for each strategy

recommended, considerations for implementation, possible funding sources, and the type of assessment that might be needed.

Each strategy that was recommended had a plethora of suggested funding sources that could be considered to support that particular strategy. For example, in the broad strategy of “Develop Purchasing Pools for Small Businesses,” the suggested funding sources from the break-out groups included: state seed money for start-up; state provided/established stabilization fund; self-funded or self sufficient; employer cost sharing; employee funding; state funding; foundation funds; federal reallocation of existing resources and tapping into new funds; and finally, a mix of state, federal, employer, employee and insurance company money to fund creation of plan, tobacco settlement funds and tax credits to employees as well as employers. It became clear that in order to reach agreement on broad strategies details on funding options would have to be deferred.

Until the specific strategies for implementation are identified, it would be premature to attempt to develop a cost structure and amount associated with each of the strategies presented. When specific strategies are identified as practical for potential policy implementation the funding sources suggested by the Illinois Assembly participants will be given serious consideration. At that time the cost structure and level should be determined consistent with standard actuarial methods used in public insurance/health efforts. The Assembly recognizes that costs are a major issue and must be given consideration prior to any final decision being made regarding policy implementation.

The Illinois Assembly process produced very good ideas that should receive continued scrutiny. The next steps in this project involve making determinations as to the specific steps Illinois should pursue. We have received additional funding from HRSA to continue the effort.

IV. Appendix

A. Detailed Ballot Results – Top Four Strategies

Participants in the July session voted in six categories. The categories consisted of the five target populations and a category of strategies that cut across populations. The target populations selected for consideration have a high population of uninsured individuals or families. They are: Young Adults; Working Uninsured; Children; Small Employers; and Hispanics and Other Minorities. This section reports on the top four strategies per category that resulted from the ballots. The top strategy in each category received significantly more votes than the next three strategies. The language in this

section is the language that is on the ballots. It is somewhat difficult to read but we have chosen not to edit it. It also contains a brief description of each target population. It should be noted that in some cases several similar options are grouped together in one strategy number.

Young Adults

A young adult is defined to be between ages 19-29. Approximately one-third of the 18 million young adults of college age attend college full time and are very likely covered under their parent's health insurance policies or through their college or university. Approximately 1.3 million (19%) college age young adults are uninsured. There is a strong direct relationship between young adults from higher-income families, college or university attendance, and insurance coverage. Twelve million young adults age 19-23 are not in school and 5 million are not insured (38%). Males are less likely to be covered than females and minorities are less likely to be covered than whites. Of young adult workers (19-29), 42% are covered by their employer's insurance. Only 61% of employers of young adults offer employer sponsored insurance and 35% of young workers are not eligible for their employer's sponsored plan (look back provisions, part time or temporary positions or waiting time effect eligibility). Thirty percent (30%) of young adults (12 million or 1/4 of the total 44 million uninsured) were without insurance in 1999.

The top four strategies for young adults are:

1. Create new incentives for employers to provide coverage.
Change state law.
Provide employer incentive for part time workers.
2. Expand family plan eligibility.
Extend dependent coverage insurance options.
Extend dependent coverage by X years (based on data) for single young adults.
3. Educate young adults on social responsibility of health insurance and costs of not having health insurance.
Communicate the value of being insured and the options available.
Educate individuals on the cost of health care.
Educate young adults on the need for health insurance and the possible medical financial risks.
Educate the young adult of the need, importance, and cost effectiveness of health insurance.
Market the cost of not being insured.

4. Expand the current public insurance programs to include young adults.
Extend public insurance to young adults.

Children

Hispanic and other minority or ethnic group children are more likely to be uninsured and more likely to come from low-income families than white non-Hispanic children. Twenty three percent (23%) of poor children are uninsured. Almost 14% of children less than 6 years old are uninsured, with uninsured rates being 13.3% and 14.4% respectively for children 6-11 and 12-17 years old. There are about 1.3 million families in which children are insured but parent(s) are uninsured. Most are low-income families with children eligible, and parents ineligible for Medicaid/SCHIP. The rate of uninsured children is decreasing and the rate of uninsured parents is increasing. In states where public insurance programs have been expanded to include the parents of eligible children, there are 40% lower rates of uninsured children.

The top four strategies for children are:

1. Expand KidCare eligibility.
Expand income eligibility levels for KidCare.
Expand KidCare income eligibility to greater than 185%.
Raise KidCare eligibility to 200% Federal Poverty Level (FPL) and apply for federal waiver to go higher.
Expand KidCare to family care.
Extend KidCare to all children – no categorical exclusions.
2. Improve outreach, enrollment and access to Medicaid/KidCare.
Reach single parent and hard-to-reach families with Medicaid/KidCare eligibility.
Use non-traditional marketing strategies.
Simplify KidCare/Medicaid enrollment.
Validate insured status of all children in Illinois.
3. Develop state program that allows all uninsured children enrollment regardless of income/citizenship.
4. Make dependent coverage affordable to employers and employees.
Provide low-income employees with a choice of having KidCare/Medicaid or the employer based program rebate.

Hispanics and Other Minority Groups

Data on insurance coverage shows that the rate of uninsurance among racial/ethnic minorities is high, but that Hispanics have the highest rates among minority groups. Therefore, the Assembly considered the issue of racial/ethnic disparities in insurance coverage with an emphasis on Hispanics.

Hispanics are among the poorest segment of minority groups, with 59% having family incomes below 200% of the FPL as compared to whites at 23%. While 87% of uninsured Hispanics are from working families, they have access to Employer Sponsored Insurance (ESI) only two-thirds as often as whites (58% as compared to 85%). They also have the highest rate of uninsurance for children compared to other minority groups. Young adult Hispanics (18-29) are 50% less likely to be insured than any other group with the male Hispanic population uninsurance rate at 56% as compared to 42% for females. Undocumented immigrants have no access to Medicaid or job-based coverage while documented but non-citizen immigrants have reduced access to Medicaid.

The top four strategies for Hispanics and other minority groups are:

1. Eliminate immigration status as a barrier.
Support the undocumented population.
Open up Medicaid for undocumented immigrants using state dollars.
Get undocumented kids into KidCare/Medicaid.
2. Design special Outreach programs (information and referral).
Market available insurance to the population to increase uptake levels using health care clinics.
Market/educate/outreach through ethnic associations/churches or chambers of commerce in ethnic neighborhoods, etc.
Design and market insurance to cultural groups.
3. Support and encourage more community health centers with high minority populations tailored to the specific minority needs. Increase in preventive care, job access, and insurance access.
4. Educate Hispanics and other minority groups in health insurance products.
Offer culturally competent education regarding accessing and use of health insurance.
Develop educational program regarding what is already available – keeping in mind changing cultural and family norms.

Develop awareness and intake program that lets people know what is available through services and agencies that they use and trust. (Churches, ESL, CBOs, free clinics, schools, etc.)

Develop KidCare outreach enrollment programs for Hispanic and other minority groups.

Small Employer

Nearly half of all uninsured workers are either self-employed or work for firms with fewer than 25 employees. Another 14% are in firms with 25-99 workers. Firm size is a factor for those employers who do offer health coverage, with 60% of businesses with 3-9 workers offering health coverage in 2000, versus 97% of firms with 50 or more workers. Two-thirds of small firms offering insurance provide coverage through a managed care plan with 10% of small firms offering a choice of plans compared to 84% of large firms. Of those firms that do not offer health coverage 69% stated they could not afford coverage and 56% stated that their revenues were too uncertain to commit to health insurance. Other reasons given by small employers who do not provide health coverage are: 61% - employees get coverage elsewhere and 54% - employees cannot afford their premium contribution. Small employers did offer suggestions as to what incentives they would respond to in order to provide health coverage to their employees. Sixty four percent (64%) stated they would seriously consider offering insurance if government subsidized their premiums. Eighty six percent (86%) favored tax breaks to help low-wage workers obtain coverage. Premiums are more volatile because small-group coverage generally involves medical underwriting, so workers with pre-existing medical conditions affect premiums. Very small firms (fewer than 5 employees) find that insurers do not market to them because they are viewed as too risky.

The top four strategies for small employers are:

1. Develop statewide purchasing cooperative. (Look at California plan.)
 Develop a group purchasing pool by geographical region.
 Create large risk pool for small businesses.
 Create 3rd party administrative pools.
2. Reduce/stabilize costs for small employers.
 Offer a small incentive (business voucher) to partially offset costs.
 Subsidize price of insurance to low wage employees.

3. Revise government regulations to encourage flexibility/creativity in the development of affordable health plans.
Make Illinois insurance laws/regulations more flexible for competition.
4. Capitalize on CMS Health Insurance buying leverage for small employers.

Working Uninsured

The working uninsured are defined as working individuals ranging in age from 19–64. They are individuals who are single, or a single head of household, married with children or are married without children. The working uninsured are poor or near-poor, change jobs frequently, hold more than one job, have low wages, work part time and work for small companies. In 1998 over 45% of low-income workers were uninsured. Their wage earnings are above the eligibility requirements for public programs (e.g., Medicaid, SCHIP). Over 42.6 million workers (the majority of the uninsured population) and their families do not have access to affordable insurance through their employer (even though they may have technical access because their employer offers coverage with relatively expensive premiums). Eighty percent (80%) of uninsured Americans live in households where at least one member of the household is employed. In more than three-quarters of families all members have health coverage, however in one of seven families only some members are insured. About 9 million parents are uninsured.

The top four strategies for the working uninsured are:

- I. Expand family care for families that qualify for KidCare/Medicaid.
Create family care with expanded buy-in options.
Expand SCHIP (KidCare) programs with state and federal matched dollars.
Bring parents of KidCare children in by expanding eligibility to allow parents. Increase the income levels to include low and moderate-income families.
Expand KidCare to families.
Employers promote KidCare and family care to employees.
Increase family care through KidCare (SCHIP) expansion and employee subsidy for employer sponsored plans.
Increase state flexibility for KidCare.
Expand Medicaid to households to a significantly higher level. Include public/private subsidies to 200% of the federal poverty level.
Outsource marketing of KidCare Rebate.
Outsource administration of KidCare/Family Care plans like Illinois Comprehensive Health Insurance Plan (ICHIP).
Increase family care.

Expand Medicaid option – medical sliding scale, premium subsidy, increase income eligibility.

2. Create employer incentives to offer health insurance.
Assist employers with finding affordable health insurance products for their employees.
Design portable mandatory employer-based insurance.
Encourage employer sponsored minimum benefits package.
Assist employee with finding affordable health insurance products.
Explore feasibility to offer voluntary ESI program on income-based premiums sharing.
3. Develop a small business purchasing pool.
Combine purchasing pool with reinsurance.
Create community-based networks encompassing community hospitals and individual providers.
Develop group purchasing pool on a geographical basis.
Encourage private purchasing pools.
4. Carry out multi-pronged strategy including developing a new affordable product, family care expansion, affordable products, preventative services, CHC expansion, pre-payment through savings (IRAs), low end preventative and high end catastrophic products, reinsurance, review of “no frills” insurance requirements, risk pooling, and buying into state employee plan.

Summary of Strategies (Cross Population)

In addition to voting on the strategies by target populations that resulted from the small group sessions, participants voted on a listing of strategies that appeared in more than one target population strategy list. The cross population summary of strategies was developed after evaluation of the target population strategies. Voting results for the top priority approached consensus, however there was a drop off in the numbers for the next three strategies.

The top four cross population strategies are:

1. Expand family care for families that qualify for KidCare (SCHIP)/Medicaid.
2. Carry out multi-pronged strategies including: develop a new affordable product, family care expansion, preventive services, Community Health

Care (CHC) expansion, pre-payment through savings (IRA), catastrophic coverage and reinsurance.

3. Create employer incentives to offer health insurance to full time and part time employees. (Portable mandatory employer-based insurance.)

(Note: Formatting problems in preparation of the ballot resulted in the portable mandatory language being attached to the employer incentive language. There was considerable discussion of this at the final Assembly meeting with some thinking it should be deleted and others wanting to retain the language. Based on the conversation it appears that most of those who voted for this ballot item were only voting for incentives while others were voting for both concepts. We consider creating employer incentives as the strategy on which there was consensus, not portable mandatory employer-based insurance.)

- 4.* Provide for a single payer that preserves private sector involvement. Not single provider.
- 4.* Develop statewide (or regional) purchasing cooperative.

* The last two strategies are tied.

B. Chart of Strategies by Topic

The Chart of Strategies by Topic considers the top four solutions across the six categories in topical order. Strategies have been categorized by topics that appeared across categories most regularly. Those topics are: family care options; expansion of coverage for children; outreach/education/marketing activities; employer options; legislative activities; preventive services and new product development; and community-based alternatives. Reading down the columns the general topics are highlighted in gray, and beneath each broad heading are the choices that reflect that topic. Each topic may have strategies from any, or all, of the target population categories. Across the top of the chart are the target population categories. Check marks (X's) reflect the option under any given broad category which was selected by a specific target population. For example, the first line under Family Care Options is *Include parents of eligible children in KidCare/Medicaid*. Reading across the line there is a check under *Working Uninsured* and another check under *Summary of Strategies*. This indicates that the strategy *Include parents of eligible children in KidCare/Medicaid* was prioritized in the first four choices of both target populations. As can be noted there are a number of strategies that overlap more than one target population. (For more detailed information on each of the target groups *Fact Sheets* have been placed in the Appendix.)

Chart of Strategies by Topic	Working Uninsured	Children	Small Employers	Hispanics & Other Minorities	Young Adults	Summary of Strategies
Family Care Options						
Include parents of eligible children in Kid-Care/Medicaid	X					X
Expand Kid-Care to family care	X	X				
Increase qualifying income percentages to include moderate income families	X					
Expand family plan eligibility, extend dependent coverage	X				X	
Increase family care	X					X
Extend public insurance					X	
Expand Medicaid at a significantly higher level (public/private subsidies to 200% of FPL)	X					
Expand Medicaid option - medical sliding scale, premium subsidy, increase income eligibility	X					
Create family care with extended buy-in options	X					
Subsidize price of insurance to low wage employees			X			
Reach single parent and hard-to-reach families with Medicaid/Kid-Care eligibility	X					
Eliminate immigration status as a barrier				X		
Support undocumented population				X		
Buy-in to state employee plan	X					
Expand Coverage for Children						
Extend Kid-Care to all children - no categorical exceptions (include undocumented children)		X		X		
Expand Kid-Care eligibility to 200% of more of the FPL	X	X				

Expand SCHIP (Kid-Care) programs with state and federal matched dollars	X					
Simplify public program enrollment		X				
Validate insured status of all children in Illinois				X		
Develop state program that allows all uninsured children enrollment regardless of income/citizenship		X		X		
Open up Medicaid for undocumented immigrants using state dollars				X		
Get undocumented kids into Kid-Care				X		
Outreach/Education/Marketing Activities						
Educate all groups on the cost of health care, need for insurance and financial risk	X			X	X	
Communicate the value and need for health insurance	X				X	
Improve marketing techniques through expansion, creative activities, and ethnic groups		X			X	
Outsource marketing of Kid-Care rebate and administration	X					
Design special outreach programs (information and referral)				X		
Market/educate/outreach through ethnic associations/churches or chambers of commerce in ethnic neighborhoods, etc.				X		
Design and market insurance to cultural groups				X		
Develop awareness and intake program that lets people know what is available through services and agencies that they use and trust (churches, ESL,				X		

CBOs, free clinics, schools, etc.)						
Improve outreach, enrollment and access to Medicaid/Kid-Care						
Employer Options						
Develop regional, or statewide, purchasing cooperatives/pools	X					X
Combine purchasing pool with reinsurance	X					
Encourage private purchasing pools	X					
Stabilize or reduce costs for small employers						
Subsidize employer sponsored insurance (ESI)			X			
Capitalize on CMS Health Insurance buying power leverage for small employers						
Make dependent coverage affordable to employers/employees		X				
Create new incentives for employers to provide coverage	X		X		X	
Provide incentives for employers to cover full-time and part-time workers			X		X	X
Assist employers in finding affordable health insurance products for employees	X					
Design portable mandatory employer-based insurance	X					
Encourage employer sponsored minimum benefits package	X					
Explore feasibility to offer voluntary ESI program on income-based premium sharing	X					
Extend dependant coverage by X years (based on data) for single young adults					X	

Employers promote Kid-Care and family care to employees	X					
Legislation Activities						
Make government regulations and legal environment more flexible to health insurance environment			X			
Make Illinois insurance laws/regulation more flexible for competition			X			
Eliminate immigration status as a barrier					X	
Extend public insurance to young adults	X				X	
Increase state flexibility for Kid-Care	X					
Pre-payment through savings (IRAs)	X					X
Preventative Services and New Product Development						
Develop new affordable products	X					X
Low end preventative and high end catastrophic products	X					X
Reinsurance	X					
Review of “no frills” insurance requirements	X					
Provide for a single payor that preserves private sector involvement. Not a single provider						X
Community-based Alternatives						

Create community-based networks encompassing community hospitals and individual providers	X					
CHC expansion	X					X
Preventative services	X					X
Support and encourage more community health centers with high minority populations tailored to the specific minority needs. Increase in preventive care, job access, and insurance access				X		

C. Details on Tabulation Process

Balloting Procedure Used by the Illinois Assembly

In order to rank strategies previously identified in small group break out sessions a ballot was developed listing all previously identified options. Strategy options were categorized according to each targeted population group, e.g., all policy options that were generated under the “Young Adult” category were grouped under that category while those identified under “Working Uninsured” were grouped under the Working Uninsured category, etc. There were six (6) categories: the Working Uninsured; Young Adults; Children; Small Employers; Hispanics and Other Minorities; and an artificially generated category titled Summary of Strategies, which was a combination of all of the strategies identified in all of the break-out groups that appeared in more than one category.

Ballots were distributed to the registrants of the Illinois Assembly July meeting. Each registrant received three votes per category for each of the 6 categories. Registrants were allowed to cast all three votes for one strategy or one vote each for three different strategies within a category.

Voters cast their votes using one (1) as the most preferred, two (2) as the second choice, and three (3) as the third choice. When tallying votes each number one choice received a three, each number two choice received a two, and each number three choice received a one, as follows:

First Preference:	Vote=1	Weight=3
Second Preference:	Vote=2	Weight=2
Third Preference:	Vote=3	Weight=1

This was done in order to allow individuals to cast votes in a 1, 2, 3 priority order (hoping to reduce any confusion among voters). Note: This is the same effect as having voters use three for the first choice, two for the second choice and 1 for the third choice. When counting the votes the numbers were reversed in order to allow the first preferred vote to have the highest weight, the next preference the middle weight, and the third preference the lowest weight. In some cases participants chose not to vote.

After votes were weighted as stated above they were counted, and the strategies were ranked from highest to lowest numbers of votes. The top four strategies were then identified in each category. All strategies were listed in the order of ranking, with the first listed being the highest ranked, and the last listed being the lowest rank. This list was then reported to Assembly participants.

It should also be noted that first choices in each of these categories were first with huge margins while in almost all cases 2nd, 3rd, and 4th choices were substantially lower. The following charts give more detail on the results.

**RESULTS OF VOTE (1st CHOICE ONLY EACH CATEGORY)
INCLUDES SUMMARY OF STRATEGIES**

Group	Weighted Vote Count	% of Total Vote	Total Votes Received in Category
Working Uninsured	89 points	39%	196
Small Employers	76 points	34%	225
Hispanics	66 points	30%	216
Children	82 points	38%	215
Young Adults	58 points	22%	244
Summary of Strategies	66 points	31%	210

WORKING UNINSURED*

Weighted Vote Count of Top 4	% of Total Votes Cast
1. 89 points	1. 39%
6. 31 points	6. 14%
4. 30 points	4. 13%
7. 10 points	7. 4%

Ballot Number:

1. Expand family care for families that qualify for Kid-Care/Medicaid.
 Create family care with expanded buy-in options.
 Expand SCHIP (Kid-Care) programs with state and federal matched dollars.
 Bring parents of Kid-Care children in by expanding eligibility to allow parents.
 Increase the income levels to include low and moderate-income families.
 Expand Kid-Care to families.
 Employers promote Kid-Care and family care to employees.
 Increase family care through S-CHIP – Kid-Care expansion and employee subsidy for employer-sponsored plans.
 Increase state flexibility for Kid-Care.
 Expand Medicaid to households to a significantly higher level. Include public/private subsidies to 200% of the federal poverty level.
 Outsource marketing of Kid-Care Rebate.
 Outsource administration of Kid-Care/Family Care plans like I-CHIP.
 Increase family care.
 Expand Medicaid option – medical sliding scale, premium subsidy, increase income eligibility.

6. Create employer incentives to offer health insurance.
 Assist employers with finding affordable health insurance products for their employees.
 Design portable mandatory employer-based insurance.
 Encourage employer sponsored minimum benefits package.
 Assist employee with finding affordable health insurance products.
 Explore feasibility to offer voluntary ESI program on income-based premiums sharing.

4. Develop a small business purchasing pool.
 Combine purchasing pool with reinsurance.

Create community-based networks encompassing community hospitals and individual providers.

Develop group-purchasing pool on a geographical basis.

Encourage private purchasing pools.

7. Carry out multi-pronged strategy including developing a new affordable product, family care expansion, affordable products, preventative services, CHC expansion, pre-payment through savings (IRAs), low end preventative and high end catastrophic products, reinsurance, review of “no frills” insurance requirements, risk pooling, and buying into state employee plan.

* Note: Total votes cast in this category - 196

SMALL EMPLOYER*

Weighted Vote Count of Top 4	% of Total Votes Cast
1. 76 points	1. 34%
5. 24 points	5. 11%
2. 19 points	2. 8%
10. 16 points	10. 7%

Ballot Number:

1. Develop statewide purchasing cooperative. (Look at California plan.)
Develop a group purchasing pool by geographical region.
Create large risk pool for small businesses.
Create 3rd party administrative pools.
5. Reduce/stabilize costs for small employers.
Offer a small incentive (business voucher) to partially offset costs.
Subsidize price of insurance to low wage employees.
2. Revise government regulations to encourage flexibility/creativity in the development of affordable health plans.
Make Illinois insurance laws/ regulations more flexible for competition.
10. Capitalize on CMS Health Insurance buying leverage for small employers.

* Note: Total votes cast in this category - 225

CHILDREN*

Weighted Vote Count of Top 4	% of Total Votes Cast
1. 82 points	1. 38%
3. 33 points	3. 15%
2. 29 points	2. 13%
4. 25 points	4. 12%

Ballot Number:

1. Expand Kid-Care eligibility.
Expand income eligibility levels for Kid-Care.
Expand Kid-Care income eligibility to greater than 185%.
Raise Kid-Care eligibility to 200% poverty and apply for federal waiver to go higher.
Expand Kid-Care to family care.
Extend Kid-Care to all children – no categorical exclusions.
3. Improve outreach, enrollment and access to Medicaid/Kid-Care.
Reach single parent and hard-to-reach families with Medicaid/Kid-Care eligibility.
Use non-traditional marketing strategies.
Simplify Kid-Care/Medicaid enrollment.
Validate insured status of all children in Illinois.
2. Develop state program that allows all uninsured children enrollment regardless of income/citizenship.
4. Make dependent coverage affordable to employers and employees.
Provide low-income employees with a choice of having Kid-Care/Medicaid or the employer based program rebate.

* Note: Total votes cast in this category - 215

YOUNG ADULTS*

Weighted Vote Count of Top 4	% of Total Votes Cast
8. 58 points	8. 22%
4. 40 points	4. 15%
1. 35 points	1. 14%
2. 34 points	2. 13%

Ballot Number:

8. Create new incentives for employers to provide coverage.
Change state law.
Provide employer incentive for part-time workers.
4. Expand family plan eligibility.
Extend dependant coverage insurance options.
Extend dependant coverage by X years (based on data) for single young adults.
1. Educate young adults on social responsibility of health insurance and costs of not having health insurance.
Communicate the value of being insured and the options available.
Educate individuals on the cost of health care.
Educate young adults on the need for health insurance and the possible medical financial risks.
Educate the young adult of the need, importance, and cost effectiveness of health insurance.
Market the cost of not being insured.
2. Expand the current public insurance programs to include young adults.
Extend public insurance to young adults.

* Note: Total votes cast in this category - 244

HISPANICS*

Weighted Vote Count of Top 4	% of Total Votes Cast
4. 66 points	4. 30%
1. 31 points	1. 14%
6. 30 points	6. 14%
7. 24 points	7. 11%

Ballot Number:

4. Eliminate immigration status as a barrier. Support undocumented population.
Support the undocumented population.
Open up Medicaid for undocumented immigrants using state dollars.
Get undocumented kids into Kid-Care/Medicaid.

1. Design special Outreach programs (information and referral).
Market available insurance to the population to increase uptake levels using health care clinics.
Market/educate/outreach through ethnic associations/churches or chambers of commerce in ethnic neighborhoods, etc.
Design and market insurance to cultural groups.

6. Support and encourage more community health centers with high minority populations tailored to the specific minority needs. Increase in preventive care, job access, and insurance access.

7. Educate Hispanics and other minority groups in health insurance products.
Offer culturally competent education regarding accessing and use of health insurance.
Develop educational program regarding what is already available – keeping in mind changing cultural and family norms.
Develop awareness and intake program that lets people know what is available through services and agencies that they use and trust. (Churches, ESL, CBOs, free clinics, schools, etc.)
Develop Kid-Care outreach enrollment programs for Hispanic and other minority groups.

* Note: Total votes cast in this category - 216

SUMMARY OF STRATEGIES*

Weighted Vote Count of Top 4	% of Total Votes Cast
1. 66 points	1. 31%
5. 24 points	5. 11%
4. 20 points	4. 10%
2. & 7. 16 points	2. & 7. 8%

Ballot Number:

1. Expand family care for families that qualify for Kid-Care/Medicaid (SCHIP).
5. Carry out multi-pronged strategy including develop a new affordable product, family care expansion, preventive services, CHC expansion, pre-payment through savings (IRA), catastrophic coverage and reinsurance.
4. Create employer incentives to offer health insurance full time and part time. (Portable mandatory employer-based insurance.)

(Note: Formatting problems in preparation of the ballot resulted in the portable mandatory language being attached to the employer incentive language. There was considerable discussion of this at the final Assembly meeting with some thinking it should be deleted and others wanting to retain the language. Based on the conversation it appears that most of those who voted for this ballot item were only voting for incentives while others were voting for both concepts. We consider creating employer incentives as the strategy on which there was consensus, not portable mandatory employer-based insurance.)

2. Provide for a single payor that preserves private sector involvement. Not single provider.
7. Develop statewide (or regional) purchasing cooperative.

* Note: Total votes cast in this category - 210

D. Letter from the Insurance Industry

August 7, 2001

Madelynn L. Brown
Assistant Director
Illinois Department of Insurance
100 West Randolph, Suite 15-100
Chicago, IL 60601

Dear Ms. Brown:

The members of the "Insurance Caucus" that took part in the Illinois Assembly meetings July 10 – 12, 2001 addressing the issue of covering the uninsured citizens of Illinois submit the following response paper for consideration.

The deliberations of the Illinois Assembly provided the promise of bringing the issue of the uninsured into the spotlight. As representatives of the insurance industry and the agents and brokers who market and sell its products, we have long struggled with this issue. Given this, we believe that our contribution to the Illinois Assembly at this point is a thoughtful response paper. We believe that a vote to prioritize the strategies would mean far less than a discussion of the issues and possible solutions.

The representatives of the Illinois insurance industry and insurance agents and brokers believe that the answer to solving the plight of the uninsured in Illinois is found in a strong, competitive private health insurance market fostered by government cooperation. The current system is employer-based. Since nine in ten insured Americans receive health insurance benefits through their employer, according to the Health Insurance Association of America, any reform of the market to increase access should preserve and build upon the current employer-based delivery system where possible.

Solutions that hold promise are those that promote a competitive market and foster development of new affordable health insurance products. We support private insurance market solutions for more affordable products where feasible and believe in lessening regulations proven to provide little value to the consumer, providing financial incentives for employers and individuals, and molding incentives for insurers and provider groups to work together in certain areas will prove more viable in both the near and long term future. Through a healthy, competitive market, consumers are able to access efficient and responsive products and mechanisms at affordable rates.

Recommendation: Overall we support efforts that encourage health insurance carriers to bring new innovative products to the marketplace. By

streamlining current legislative and regulatory and approval requirements for insurance products, carriers would have an incentive to develop a new generation of products to meet the unique needs of this population. For example, we need to look at a "fast-track" approval mechanism, offering options to differentiate employers with 10 or less employees, etc. Our caucus agrees this will provide assistance to the target populations discussed at the Illinois Assembly.

Comments: We want to take this opportunity to present some research on how our recommendation will affect certain target populations. According to research conducted by The Commonwealth Fund, "About 24 million U.S. workers, often employees of small firms, have no health insurance. Together with their families, these "working uninsured" comprise the vast majority of all uninsured people in this country."⁵ According to the 1997 CPS, about a quarter of the uninsured are self-employed or work in firms with 10 or fewer employees. Therefore, it makes sense to understand the reasons they lack insurance coverage and concentrate our efforts on addressing those specific obstacles.

The Kaiser Family Foundation/Health Research and Educational Trust *2000 Annual Employer Health Benefits Survey* found that three-quarters of small employers (3-199) do not offer coverage due to high premiums. Studies indicate that small businesses are least likely to offer health insurance to their employees, often due to costs. Even when employers do offer coverage, many employees decline it because they cannot afford the premiums or they are young and healthy and do not feel it is necessary. Nationally, around 2.5 million individuals turned down coverage offered by their employers in 1997.⁶ The Kaiser survey found that the take-up rate for employees offered insurance by their employer ranges from 76% to 83%. The take-up rate increases as the size of the firm increases. The sole exception to this statement is among jumbo firms (1,000-4,999 workers) where the rate drops from 83% to 79%. Sadly, the Midwest lags behind the rest of the country on take-up rates. Even in the government sector, take-up rates are not 100%. State and local government workers cover about 84% of their workers. The government sector employees take-up rate is 94%.

The insurance market has the potential to affect change by developing new and distinct products that reach out to employers and their employees. More flexible plan designs with varying cost sharing schemes (i.e., high deductibles, etc.) could provide more affordable and attractive options that better meet their unique health care needs. Digital health plans that bring more choice and flexibility and less costs to consumers are also beginning to be offered in the market place and "dependent-only" or other

⁵ Silow-Carroll, S., Waldman, K., & Meyer J (2001, February). "Expanding Employment-Based Health Coverage: Lessons From Six State and Local Programs. [The Commonwealth Fund](#).

⁶ See Footnote 1.

target population products would fill many holes. As these types of innovative products come to market and are made available to consumers, we believe they could help minimize some of the barriers facing the working uninsured today.

Recommendation: We also support limited State incentives to employers and individuals to target certain populations.

Comments: We support a limited tax credit assistance program to encourage employers to offer health insurance benefits to individuals to take part in group health plans and creating a premium assistance program for low –income working adults and young adults who meet financial requirements. By enrolling employees in private sector programs through their employers, the employees become more knowledgeable about private sector insurance system and stronger ties are developed linking them into the world of work. Every effort that can be made to equate work with a better lifestyle and better economic outcomes through wages and benefits achieves broader societal goals than a government health program can achieve.

Tax credits could improve affordability and increase access to private group health insurance in three key groups: 1) small businesses with high risk individuals; 2) start-up businesses; and 3) low income employees. Under such a tax credit program small businesses offering group benefit plans to their employees would be protected from rising health coverage costs due to catastrophic illnesses by some tax offset. Additionally, start-up businesses would see less initial capital depleted by health benefit plan establishment and can begin to attract potential employees. Finally, the low-income employees would have a financial incentive to participate in employer offered group health plans through a return in taxes.

Offering premium assistance for working young adults who meet a certain financial threshold to assist them in paying their employee contributions would provide greater access to private health insurance coverage with less cost to the government and taxpayers. It would also minimize any incentives for individuals who are currently enrolled in employer-sponsored coverage to decline that coverage and enroll in a state-subsidized program.

In reviewing some of the literature the Department made available on its website, it appears that when young adults are offered health insurance coverage, they are only *slightly* less likely to enroll in coverage than their older counterparts, meaning they would like coverage.⁷ This study, "*Health Insurance: On their own: Young adults living without health insurance*", goes on to state that 17 percent, or close to one-fifth of

⁷ Quinn, K., Schoen, C. & Buatti, L. (2000, May). Health Insurance: On their own: Young adults living without health insurance. The Commonwealth Fund. [On-Line]. Available HTTP: http://www.cmwf.org/programs/insurance/quinn_ya_391.asp [2001, June 8]

uninsured young workers are offered coverage, but decline it, the most common reason given is money. Further, low-wage employers who offer coverage tend to require employees to make larger dollar contributions.⁸ These findings suggest that more, not less, emphasis on the value of work place benefits should be considered. Young adults who see a job as merely a paycheck are less likely to view their job as a stepping-stone to financial independence and personal growth.

A premium assistance program for low-income individuals in the workplace could considerably improve their ability to purchase coverage. If coverage is available to them through their employer, it makes more sense to maintain employer-based coverage rather than enrolling them in a state-run program. This was an important consideration in the KidCare Rebate program. That program recognized that providing assistance to families to pay for their employer-based insurance provided families an opportunity to maintain continuity of care among a network of medical providers. Also, it bypassed the stigma discussed in the Assembly's focus groups of a public assistance program. If you consider the average monthly premiums compared with current employee contribution levels, there are potentially significant savings to the state if it adopts a premium assistance program as opposed to a total buy-in program for all young adults. For example, according to the Medical Expenditure Panel Survey (MEPS) -- IC Employer Survey for 1998, the average monthly premium for a typical Illinois employee in a firm of any size is \$463.91 for family coverage and \$181.65 for single coverage. The monthly premiums for firms with 0 to 50 employees are greater at \$484.28 for family coverage and \$198.85 for single coverage. The average monthly employee contribution is higher for firms with 50 and fewer employees, ranging from \$35.80 for single coverage to \$148.21 for family coverage. The survey also indicates that lower wage employees tend to have higher contribution levels.⁹

Using these averages as an illustration, the state would only pay \$35.80 a month for a single employee of a small employer with 50 or fewer employees (the employee's contribution level) as opposed to \$198.85 per month to fully subsidize the entire premium through a state-run program. The table below illustrates the potential annual savings to the state for one person with single coverage or family coverage employed by a small employer, using the premium estimates provided in the MEPS survey.

Type of Coverage	Avg. annual premium	Estimated annual state costs for premium assistance	Estimated annual state costs for full subsidy	Estimated annual savings to the state
Single	\$2,386.20	\$429.60	\$2,386.20	\$1,956.60

⁸ Quinn, K., Schoen, C. & Buatti, L. (2000, May). Health Insurance: On their own: Young adults living without health insurance. The Commonwealth Fund. [On-Line]. Available HTTP: http://www.cmwf.org/programs/insurance/quinn_ya_391.asp [2001, June 8]

⁹ Wicks, E. (2000, June). Health Purchasing Coalitions Struggle to Gain Bargaining Clout: Small Size and Lack of Support from Health Plans are Factors. Health Care Financing & Organization Brief.

Coverage				
Family Coverage	\$5,811.36	\$1,778.52	\$5,811.36	\$4,032.84

As illustrated, providing premium assistance to working uninsured individuals would require the state to pay only a portion of the premium, rather than fully subsidizing the cost of an entire premium. This appears to be a more cost-effective and practical approach to reaching this population of the uninsured.

Conclusion

In addition to the above recommendations, we wish to make three important points as you consider the State's options.

First, we strongly caution against a State government buy-in approach or creating more "low-cost" risk pools. This approach has the threat of attracting individuals already participating in private group insurance or encouraging them to turn down coverage by their employer. This could place a particular burden on small employers. If small employer groups lose young and healthy members from their plans to a state subsidized program, it will be more difficult for carriers to balance the costs of unhealthy risks in these groups and ultimately cause an increase in their insurance rates. In a voluntary market when the cost of health care is increasing rapidly across the country, a proportional distribution of low-risk groups helps stabilize the rates for the block as a whole. When the pool of low-risk groups shrinks, the cost for the remaining groups escalate at a faster rate than if the low-risk groups were in the pool. If this occurs, affordable health insurance will be even further out of reach for small employers and their employees in the state.

According to a recent study on the experience of the Health Insurance Plan of California (HIPC), the country's first state-run health insurance purchasing alliance for small firms, "pooled purchasing alone cannot sustainably lower the cost of health insurance enough to increase coverage among small business employees."¹⁰ The study further states "...an examination of the HIPC's experience also raises doubts as to whether pooled purchasing has yielded significant savings relative to options available in the small-group market. It has been reported that the HIPC's initial premiums were lower than those outside the HIPC. More recent data, however, provide no evidence that HIPC rates are still lower."¹¹

A recent General Accounting Office (GAO) study of small group purchasing cooperatives found that these arrangements have not been able to enroll sufficient

¹⁰ Yegian, J., Buchmueller, T., Smith, M., & Monroe, A (2000, September/October). The Health Insurance Plan of California: The First Five Years. Health Affairs.

¹¹ See Footnote 3.

numbers to provide bargaining leverage. Even the Pacific Health Advantage with 144,000 covered lives accounts for only 2% of the small group health insurance market in California. In general, all coops reviewed had less than 5% of the state's market.

Another study on health purchasing cooperatives (HPCs) found that "Virtually all HPCs have lost PPOs, in part because of adverse selection. Not having a PPO option has exacerbated HPCs' problems competing in the small-group market."¹² The study, which evaluated several HPCs around the county, found that when PPOs were sold through HPCs, they only attracted unhealthy or high-risk individuals. Even enrollment in the largest HPCs in California and Florida accounted for only 5 percent of small group enrollment.¹³

The population groups discussed at the Assembly are too large to sustain in a HPC or risk pool setting without moving towards a "single payor system," which we do not support.

Second, any state reforms should be carefully considered so that we do not exacerbate the uninsured population. A study of the uninsured conducted by The Employee Benefit Research Institute (EBRI), also provides insight on state initiatives and their affect on the uninsured. The study used the U.S. Census Bureau's March 1998 Current Population Survey as its basis. The study found that state reform efforts could add to the problem of the uninsured:

- The sole effort among states to decrease the number of uninsured was the establishment of high-risk pools, resulted in only a 1.5% decrease.
- Small group community rating in conjunction with a guaranteed issue requirement increased the probability that an individual will be uninsured by 28.5%.
- Small group rating bands coupled with guaranteed issue increased the probability that an individual will be uninsured by 15.8%.
- Community rating and guaranteed issue requirements in the individual health insurance marketplace increased the probability that an individual will be uninsured by 11.3%.
- Rating bands with guaranteed issue requirements in the individual health insurance market increased the probability that an individual will be uninsured by

¹² Wicks, E (2000, June). Health Purchasing Coalitions Struggle to Gain Bargaining Clout: Small Size and Lack of Support from Health Plans are Factors. Health Care Financing & Organization Brief.

¹³ See Footnote 5.

5.1%.

- A mandate that insurance plans cover mental health increased the probability that an individual will be uninsured by 5.8%.

This analysis does much to explain how the numbers of uninsured can vary from state to state.

Third, we are aware of the President's initiative to make the Medicaid program more accessible to uninsured low income Americans. We would caution that any expansion of public programs such as Medicaid, should only be addressed in conjunction with reforming the benefit package provided recipients. Specifically, the State employee, Medicaid and Federal Employee Health Benefit Program (FEHB) benefits do not resemble the private market. As such, in order to expand any public program to cover more people there must be a resource shift away from overly rich benefits to what the market currently provides most employees. While we believe the private market recommendations discussed previously will provide access to health insurance for most Illinois citizens, we acknowledge the federal administration's Medicaid revisions.

In closing, we hope that the Illinois Assembly will advance proposals predicated on promoting innovative free-market initiatives and cost-effective improvements to current government programs. The Insurance Caucus, comprised of the insurance trade associations, insurers, brokers, agents, etc., wants to be a part of this solution and will look forward to continuing our dialogue on these important issues in the future.

Thank you for your careful consideration of our comments.

Sincerely,

Larry Barry, Illinois Life Insurance Council
Elena Butkus & Matthew Napierkowski, Illinois Association of Health Plans
Gary Fitzgerald, Harmony Health Plan of Illinois
Brian Glassman, Health Care Service Corporation
Sharon Heaton, Heaton Agency Inc.
Paul Hilling, Near North Insurance Brokerage, Inc.
Phil Lackman, Professional Independent Insurance Agents of Illinois
Pamela Mitroff, Mitroff Consulting
Michael Murphy, Humana Health Care Plans, Inc.

cc: Eric Brenner, Governor's Office
Michael Lawrence, SIU

E. Employer Letter

October 16, 2001

Ms. Madelynne Brown
Assistant Director
Illinois Department of Insurance
320 West Washington
Springfield, IL 62767

Dear Ms. Brown:

The goal of the Illinois Assembly to provide solutions to the ongoing problem of uninsured in our State is one the employer community wholeheartedly embraces. Employers have been struggling for years to provide high quality, affordable health care benefits to their employees. Unfortunately, many cost-related factors have led employers to either reduce or eliminate health care insurance as a benefit leading to a rise in working uninsured.

As initially outlined by the Department, the Illinois Assembly process seemed to be one of consensus building. A diverse group was brought together and representatives of the employer community attended the Assembly in good faith hoping to find solutions. A lot of differing views were discussed during the Assembly, some were agreed upon but many were not.

The problem is the draft report seems to indicate a consensus where there is none. Under the heading of "cross population strategies" the report lists the supposed top 4 strategies that are meant to cut across all populations. One of the strategies is the notion of developing a single payor health care system. We are perplexed and dismayed as to how this strategy made it into the top 4 when it is not listed as a strategy under any of the single population targets. Furthermore the discussion of a single payor system, while brought up in passing, was not seriously considered as a solution by anyone in the business community. We believe it is deceiving to list this "strategy" as one of consensus when it was clearly supported by a minute segment of those attending the Assembly.

Also disturbing is the fact that a strategy with clear support under all populations - creating employer incentives to provide health insurance - was diminished in its importance due to "formatting" mistakes. There is great discomfort by us to sign off on any concept that includes the idea of "portable mandatory employer-based insurance." The fact that the report ties employer incentives to portable mandatory employer-based insurance severely misrepresents what we feel was consensus by the Assembly.

We also believe that since most Illinoisans obtain their insurance through

employment, we should look at ways to lower insurance costs so that more employers can offer insurance to their employees. Your own research has shown that 64 percent of employers would consider offering insurance if there was some type of premium assistance and 86 percent favored tax breaks to offset the cost of coverage. Those opinions should not be ignored since employers are likely to remain the "consumers" of health insurance coverage for their employees.

For these reasons, we are unable to fully embrace the contents of this report and would like this letter to be included with the report. It must be stated emphatically that we in no way would support any solution that contained a provision for a single payor health care system or any type of mandatory employer-based insurance plan.

Sincerely,

Kim Clarke Maisch
NFIB

Jay Dee Shattuck
Employment Law Council

Todd Maisch
Illinois Chamber of Commerce

Rob Karr
Illinois Retail Merchants Association

Boro Reljic
Illinois Manufacturers Association

Larry Barry
Illinois Life Insurance Council

Elena Butkus
Illinois Association of Health Plans

James Stutz
St. Louis Area Business Health Coalition

Jim Mortimer
Midwest Business Group on Health

F. January Assembly Registrants

First Name	Last Name	Organization
Larry	Barry	Illinois Life Insurance Council
Matt	Baughman	Southern Illinois University - Public Policy Institute
Lucinda	Beier	Illinois State University - Applies Social

Gayle	Blair	Illinois Department of Public Health
Eric	Brenner	Office of Governor
Madelynne	Brown	Illinois Dept. of Insurance
Chuck	Budinger	Illinois Dept. of Insurance
Elena	Butkus	Illinois Association of Health Plans
Rick	Carlson	Illinois Comprehensive Health Ins. Plan
Steve	Carlson	Illinois Rural Health Association
Greg	Carney	Illinois Farm Bureau
David	Citron	Illinois Dept. of Public Aid
Gerri	Clark	Division of Specialized Care for Children
Sue	Clark	Illinois Nurse's Association
Yvonne	Clearwater	Illinois Department of Insurance
Ray	Cooke	Springfield Department of Public Health
Caryl	Cox	Program Evaluation for Education and Communities
Maria	de Guzman	Chicago Health Outreach
Steve	Derks	Advocate Health Care
Francisco	d'Escoto	United Neighborhood Organization
Jim	Duffett	Campaign for Better Health Care
Pat	Eckert	Southern Illinois University - Division of Continuing Education
Joe	Feinglass	Northwestern University - Preventative Medicine
Dan	Fulwiler	Access Community Health Network
Paul	Galligos	Rural Partners
Vickie	Gates	Academy for Health Services Research & Health Policy
Michelle	Gentry-Wiseman	Illinois Dept. of Public Health
Joy	Getzenberg	Chicago Dept. of Public Health
Lisa	Gregory	Illinois Primary Health Care Association
Dale	Griffin	Health Care Service Corporation
Robert	Haight	United Way of IL
Joseph	Harrington	Rush Medical Center
Sharon	Heaton	Heaton Agency Inc.
Aaron	Hernandez	United Power for Action and Justice - United Neighborhood
Jerry	Hickam	Southern Illinois Healthcare
Paul	Hilling	Near North Insurance Brokerage, Inc.
D.G.	Huelskoetter	
Mike	Jones	Illinois Dept. of Public Health
Julie	Kaiser	Southern Illinois University - Public Policy Institute
Fred	Kalsbeek	St. Francis Medical Center
Rob	Karr	Illinois Retail Merchants Association
Peg	Keeley	AARP of Illinois - Legislative Office
Katy	Khayyat	Dept. of Commerce and Community Affairs
Patti	Kimmel	Illinois Department of Public Health
Jan	Kirby	Illinois Comprehensive Health Ins. Plan
Mike	Koetting	University of Chicago Hospitals
Frank	Kopel	Illinois Department of Public Aid
Richard	Kotz	Consultant
Gordana	Krkic	Illinois Academy of Family Physicians
Laura	Landrum	Illinois Department of Public Health

Philippe	Largent	Illinois Primary Health Care Association
Mike	Lawrence	Southern Illinois University - Public Policy Institute
Diane	Lindblom	State Planning Grant
Debbie	Lounsberry	Senate Republican Staff
Johanna	Lund	Health Care Consultants
Kim	Maisch	National Federation of Independent Businesses
Todd	Maisch	Illinois Chamber of Commerce
Dennis	Matheis	CIGNA Healthcare of Illinois, Inc.
Bill	McAndrew	Illinois Dept. of Insurance
Holly	McCaffrey	National Alliance for the Mentally Ill
Terri	McEntaffer	Illinois Pharmacists Association
C.J.	Metcalf	Illinois Department of Insurance
Pam	Mitroff	Pamela D. Mitroff, Consulting
Shannon	Moorer	Senate Democrat Staff
Marty	Morris	Illinois Comprehensive Health Insurance Plan
Saul	Morse	Illinois State Medical Society
Jim	Mortimer	Midwest Business Group on Health
Sharon	Mumford	Department of Human Services
Mike	Murphy	Humana, Inc.
Matt	Napierkowski	Illinois Association of Health Plans
Merwyn	Nelson	Illinois Department of Public Health
Ray	Passeri	Illinois Department of Public Health
Howard	Peters	Illinois Hospital Association
Mark	Peters	Illinois Public Health Association
Georgeen	Polyak	Oak Park Department of Public Health
Matt	Powers	Illinois Department of Public Aid
Boro	Reljic	Illinois Manufacturer's Association
Sinead	Rice	Illinois Department of Insurance
Mary	Ring	Illinois Department of Public Health
Ken	Robbins	Illinois Hospital & Health Systems Association
Dick	Rogers	Illinois Association of Health Plans
Dianne	Rucinski	University of Illinois at Chicago
Paul	Sarvela	Southern Illinois University - Health Care Professions
Steve	Saunders	Department of Human Services
Robert	Schaaf	IMS Inc.
Hank	Scheff	AFSCME Council 31
Laura	Schneider	Lake County Health Department
Ralph	Schubert	Department of Human Services
Nat	Shapo	Illinois Department of Insurance
Jay	Shattuck	Employment Law Council
Ross	Silverman	SIU School of Medicine - Department of Medical Humanities
Greg	Smith	PIIAI, IAIFA, ISAHU
Susie	Smith	Illinois Department of Insurance
Jason	Speaks	Attorney General
Zack	Stamp	Zack Stamp, Ltd.
Bruce	Steiner	Illinois Department of Public Health
Jerry	Stermer	Voices for Illinois Children

Ashley	Stiller	State Planning Grant
Peggy	Stockdale	Southern Illinois University - Psychology Department
Connie	Sullinger	Illinois EPA
Bryan	Swank	Swank Insurance Agency, Inc.
Jane	Swanson	Southern Illinois University - Psychology Department
Kathryn	Taylor	Illinois Department of Public Health
Bob	Wagner	Illinois Department of Insurance
Sally Jo	Wright	State Planning Grant
Quentin	Young	Health & Medicine Policy Research Group

G. July Assembly Registrants

First Name	Last Name	Organization
Larry	Barry	Illinois Life Insurance Council
Elissa	Bassler	Public Health Futures Illinois - Illinois Department of Public Health
Matt	Baughman	Southern Illinois University - Public Policy Institute
Kim	Beggs	Community Health Initiative
Gayle	Blair	Illinois Department of Public Health
James	Bloyd	Cook County Department of Public Health
Sylvie	Bouriaux	Illinois State University - Finance, Insurance and Law
Eric	Brenner	Office of Governor
Madelynne	Brown	Illinois Dept. of Insurance
Chuck	Budinger	Illinois Dept. of Insurance
Elena	Butkus	Illinois Association of Health Plans
Rick	Carlson	Illinois Comprehensive Health Ins. Plan
Rob	Carney	Illinois Chamber of Commerce
Sue	Clark	Illinois Nurse's Association
Yvonne	Clearwater	Illinois Department of Insurance
Debra	Cole	Illinois Retail Merchants Association
Ray	Cooke	Springfield Department of Public Health
Caryl	Cox	Program Evaluation for Education and Communities
Maria	de Guzman	Chicago Health Outreach
Steve	Derks	Advocate Health Care
Brian	DeRue	House Republican Staff
Francisco	d'Escoto	United Neighborhood Organization
Kurt	DeWeese	House Democratic Staff
Mary	Dobbins	Illinois Chapter, American Academy of Pediatrics
David	Dring	Illinois Association of Health Plans
Jim	Duffett	Campaign for Better Health Care
Jim	Durkan	Community Memorial Foundation
Pat	Eckert	Southern Illinois University - Division of Continuing Education
Ray	Empereur	Rockford Health Council
Richard	Endress	Access DuPage
Gary	Fitzgerald	Harmony Health Plan
John	Frana	Community Health Initiative
Dan	Fulwiler	Access Community Health Network

Robyn	Gabel	Illinois Maternal and Child Health Coalition
Paul	Galligos	Rural Partners
Donna	Ginther	AARP of Illinois
Brian	Glassman	Blue Cross/Blue Shield of Illinois
Tiffany	Grant	
Lisa	Gregory	Illinois Primary Health Care Association
Dale	Griffin	Health Care Service Corporation
Lori	Hafel	
Robert	Haight	United Way of IL
Joseph	Harrington	Rush Medical Center
Sharon	Heaton	Heaton Agency Inc.
Jerry	Hickam	Southern Illinois Healthcare
Paul	Hilling	Near North Insurance Brokerage, Inc.
Karen	Hoffert	
Barbara	Holmes	United Healthcare
Josh	Hoyt	United Power for Action and Justice
D.G.	Huelskoetter	
Kevin	Jarvis	Illinois Public Health Association
Iris	Johnson	Illinois Health Care Cost Containment Council
Mike	Jones	Illinois Dept. of Public Health
Fred	Kalsbeek	St. Francis Medical Center
Rob	Karr	Illinois Retail Merchants Association
Joleen	Katula	United HealthCare
Vincent	Keenan	Illinois Academy of Family Physicians
Katy	Khayyat	Dept. of Commerce and Community Affairs
Patti	Kimmel	Illinois Department of Public Health
Mike	Koetting	University of Chicago Hospitals
Frank	Kopel	Illinois Department of Public Aid
Richard	Kotz	Consultant
Gordana	Krkic	Illinois Academy of Family Physicians
Phil	Lackman	Professional Independent Insurance Agents of Illinois
Laura	Landrum	Illinois Department of Public Health
Philippe	Largent	Illinois Primary Health Care Association
Kathy	LaSpina	Harmony Health Plan
Mike	Lawrence	Southern Illinois University - Public Policy Institute
Amy	Lay	Illinois Department of Public Health - Division of Health Policy
Kate	Leinweber	Governor Ryan's Office
Patrick	Lenihan	Chicago Dept. of Public Health
Diane	Lindblom	State Planning Grant
Ancelmo	Lopes	Harmony Health Plan of Illinois, Inc.
Debbie	Lounsberry	Senate Republican Staff
John	Lumpkin	IDPH
Johanna	Lund	Health Care Consultants
Kim	Maisch	National Federation of Independent Businesses
Todd	Maisch	Illinois Chamber of Commerce
Bill	McAndrew	Illinois Dept. of Insurance
Paul	McNamara	Department of Agriculture and Consumer Economics

Andrew	Melczar	Illinois State Medical Society - Health Policy Research
Pat	Merryweather	Illinois Hospital and Health Systems Association
C.J.	Metcalf	Illinois Department of Insurance
Pam	Mitroff	Pamela D. Mitroff, Consulting
John	Monahan	Annie E. Casey Foundation
Emily	Mondschein	Voices for Illinois Children - State Fiscal Analysis Project
Shannon	Moorer	Senate Democrat Staff
Marty	Morris	Illinois Comprehensive Health Insurance Plan
Jim	Mortimer	Midwest Business Group on Health
Mike	Murphy	Humana, Inc.
Matt	Napierkowski	Illinois Association of Health Plans
Merwyn	Nelson	Illinois Department of Public Health
Tim	Olmsted	State Planning Grant
Charles	Onufer	UIC-DSCC
Ray	Passeri	Illinois Department of Public Health
Steve	Perlin	Illinois Hospital & Health Systems Association
Georgeen	Polyak	Oak Park Department of Public Health
Debbie	Potts	Illinois of Educational Services
Linda	Potts	Community Health Initiative
Matt	Powers	Illinois Department of Public Aid
Boro	Reljic	Illinois Manufacturer's Association
Rachel	Reutter	Southern Illinois University
Susan	Reyman	Reyman Associates
Sinead	Rice	Illinois Department of Insurance
Margaret	Richards	Illinois Department of Public Health
Mary	Ring	Illinois Department of Public Health
Julio	Rodriguez	Illinois Department of Human Services
Dianne	Rucinski	University of Illinois at Chicago
Paul	Sarvela	Southern Illinois University - Health Care Professions
Steve	Saunders	Department of Human Services
Robert	Schaaf	IMS Inc.
Margie	Schaps	Health & Medicine Policy Research Group
Hank	Scheff	AFSCME Council 31
Laura	Schneider	Lake County Health Department
Ralph	Schubert	Department of Human Services
Dan	Shannon	Southern Illinois University - Ctr. For Rural Health & Social Service Dev.
Jay	Shattuck	Employment Law Council
Ross	Silverman	SIU School of Medicine - Department of Medical Humanities
Susie	Smith	Illinois Department of Insurance
Jason	Speaks	Attorney General
Zack	Stamp	Zack Stamp, Ltd.
Margaret	Stapleton	National Center on Poverty Law
Bruce	Steiner	Illinois Department of Public Health
Ashley	Stiller	State Planning Grant
Peggy	Stockdale	Southern Illinois University - Psychology Department
Jane	Swanson	Southern Illinois University - Psychology Department
Jeffrey	Todd	Stephenson County Health Department

Bob	Wagner	Illinois Department of Insurance
Zachary	Wichmann	Attorney General
Julie	Williamson	Southern Illinois University - Division of Continuing Education
Neil	Winston	Illinois State Medical Society
Kate	Woods	Southern Illinois University - Division of Continuing Education
Sally Jo	Wright	State Planning Grant
Theresa	Wyatt	Illinois Department of Public Aid

H. September Assembly Registrants

First Name	Last Name	Organization
Larry	Barry	Illinois Life Insurance Council
Elissa	Bassler	Public Health Futures Illinois - Illinois Department of Public Health
Matt	Baughman	Southern Illinois University - Public Policy Institute
Kim	Beggs	Community Health Initiative
James	Bloyd	Cook County Department of Public Health
Eric	Brenner	Office of Governor
Madelynne	Brown	Illinois Dept. of Insurance
Chuck	Budinger	Illinois Dept. of Insurance
Elena	Butkus	Illinois Association of Health Plans
Rick	Carlson	Illinois Comprehensive Health Ins. Plan
Greg	Carney	Illinois Farm Bureau
Gerri	Clark	Division of Specialized Care for Children
Yvonne	Clearwater	Illinois Department of Insurance
Ray	Cooke	Springfield Department of Public Health
Steve	Derks	Advocate Health Care
Brian	DeRue	House Republican Staff
Pat	Eckert	Southern Illinois University - Division of Continuing Education
Ray	Empereur	Rockford Health Council
Richard	Endress	Access DuPage
Gary	Fitzgerald	Harmony Health Plan
Robyn	Gabel	Illinois Maternal and Child Health Coalition
Paul	Galligos	Rural Partners
Joy	Getzenberg	Chicago Dept. of Public Health
Greg	Glahn	Office of the Auditor General
Brian	Glassman	Blue Cross/Blue Shield of Illinois
Dale	Griffin	Health Care Service Corporation
Robert	Haight	United Way of IL
Jerry	Hickam	Southern Illinois Healthcare
Barbara	Holmes	United Healthcare
Josh	Hoyt	United Power for Action and Justice
Kevin	Jarvis	Illinois Public Health Association
Iris	Johnson	Illinois Health Care Cost Containment Council
Mike	Jones	Illinois Dept. of Public Health
Fred	Kalsbeek	St. Francis Medical Center
Rob	Karr	Illinois Retail Merchants Association

Joleen	Katula	United HealthCare
Katy	Khayyat	Dept. of Commerce and Community Affairs
Patti	Kimmel	Illinois Department of Public Health
Candace	King	DuPage Federation on Human Services Reform
Richard	Kotz	Consultant
Gordana	Krkic	Illinois Academy of Family Physicians
Amiad	Kushner	Northwestern University
Phil	Lackman	Professional Independent Insurance Agents of Illinois
Laura	Landrum	Illinois Department of Public Health
Mike	Lawrence	Southern Illinois University - Public Policy Institute
Amy	Lay	Illinois Department of Public Health - Division of Health Policy
Diane	Lindblom	State Planning Grant
John	Lumpkin	IDPH
Johanna	Lund	Health Care Consultants
Kim	Maisch	National Federation of Independent Businesses
Barbara	Mason	SIU School of Medicine
Bill	McAndrew	Illinois Dept. of Insurance
Paul	McNamara	Department of Agriculture and Consumer Economics
Pat	Merryweather	Illinois Hospital and Health Systems Association
C.J.	Metcalf	Illinois Department of Insurance
Pam	Mitroff	Pamela D. Mitroff, Consulting
Emily	Mondschein	Voices for Illinois Children - State Fiscal Analysis Project
Saul	Morse	Illinois State Medical Society
Jim	Mortimer	Midwest Business Group on Health
Merwyn	Nelson	Illinois Department of Public Health
Tim	Olmsted	State Planning Grant
Steve	Perlin	Illinois Hospital & Health Systems Association
Howard	Peters	Illinois Hospital Association
Debbie	Potts	Illinois of Educational Services
Boro	Reljic	Illinois Manufacturer's Association
Susan	Reyman	Reyman Associates
Sinead	Rice	Illinois Department of Insurance
Dianne	Rucinski	University of Illinois at Chicago
Paul	Sarvela	Southern Illinois University - Health Care Professions
Steve	Saunders	Department of Human Services
Margie	Schaps	Health & Medicine Policy Research Group
Hank	Scheff	AFSCME Council 31
Jay	Shattuck	Employment Law Council
Paul	Simon	Southern Illinois University - Public Policy Institute
Susie	Smith	Illinois Department of Insurance
Jason	Speaks	Attorney General
Margaret	Stapleton	National Center on Poverty Law
Bruce	Steiner	Illinois Department of Public Health
Ashley	Stiller	State Planning Grant
James	Stutz	St. Louis Area Business Health Coalition
Jane	Swanson	Southern Illinois University - Psychology Department
Bob	Wagner	Illinois Department of Insurance

Angie	White	Senate Republican Staff
Blair	Whitney	Community Health Initiative
Kate	Woods	Southern Illinois University - Division of Continuing Education
Sally Jo	Wright	State Planning Grant
Theresa	Wyatt	Illinois Department of Public Aid

The following Appendices are available on the Website: www.ins.state.il.us/spg

I. Ballot Tabulations

J. Report of Small Group Deliberations (July 10-12)

K. Fact Sheet - Young Adults

L. Fact Sheet - Children

M. Fact Sheet - Minority Groups

N. Fact Sheet - Small Employers

O. Fact Sheet - Working Uninsured

P. UIC PowerPoint Slides – Report to the Illinois Assembly on the Uninsured

Q. SIUC PowerPoint Slides – Focus Groups and Interviews: Preliminary Findings

R. BRFSS PowerPoint Slides – Trends in Health Insurance Coverage in Illinois